Written on OCTOBER 17, 2011 AT 8:30 AM *by* PROSS

Lt. Cmdr. Andy Baldwin Highlights His Medical Mission in Kenya (Part 1 of 2)

Filed under UNCATEGORIZED {12 COMMENTS}

By Lt. Cmdr. Andy Baldwin, Family Medicine resident, Naval Hospital Camp Pendleton, Calif.

Jambo! This is the jovial Swahili word for hello that I have already said and heard so often here in Kenya at the Chepaiywa Health Center in the Rift Valley Province. I am participating in a month long rotation here in Western Kenya as part of my Family Medicine Residency at Naval Hospital Camp Pendleton, Calif. As third year residents, we have the opportunity to do an away rotation somewhere in the world in the specialty that we choose.

One of the key missions of Navy Medicine that I love is Humanitarian Assistance/Disaster Relief (HA/DR). Since the Indian Ocean Tsunami Response in 2004 by our Navy, HA/DR has become a key component of the overall Navy/Marine Corps Maritime Strategy. The soft power of medical diplomacy is a powerful weapon of good. During my initial operational tours, I was able to participate in several HA/DR missions in Southeast Asia and on the hospital ship USNS Comfort in Central and South America. My experiences made me a true believer in the benefits of medical diplomacy, and I developed a passion for the delivery of health care and education in underserved areas of the world.

With limited resources in these remote and sometimes austere environments, as a health care professional you are forced to practice medicine differently, in a raw and natural way, often times without a conclusive, satisfying result. But the key to measuring results in these areas is not through lab tests, MRIs, the number of relative value units generated, or a definitive diagnosis; it is through taking the pain or itch away (even if just briefly), giving someone shoes to wear, making them smile, and often times just giving a person the chance to see an actual doctor for the first time in their lives.

As I arrived to the Chebaiywa Health Center, in traditional Kenyan fashion, I was greeted in song by the local community leaders and invited to cut a ribbon between myself and the clinic entrance. The Kenyan people are highly ceremonial and make every attempt they can to welcome guests and make them feel at home. This high priority in relationships and community is what I believe has helped keep these people going in times of great crises. This is my second time to the country of Kenya and I am continually impressed by the resiliency that these people have in the midst of drought, HIV/AIDs, malaria, and lack of proper prenatal and neonatal care.

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The mortality rate for children under five years-old in the area is about one in three or 33 percent. In other areas of the country this figure approaches 50 percent. The major reasons for these rates are lack of maternity care during pregnancy, no neonatal care at birth (they deliver at home), infection (malaria is the leading cause), and malnutrition or dehydration complicated by waterborne diseases.

The Chebaiywa Health Center was started in 2008 as a result of a growing need for medical care in the Kipkaren region outside of the town of Eldoret. At the time of inception it was a simple dispensary, providing some basic medications, wound treatment and health education on hand washing, HIV/AIDs and malaria. Over the past few years with funding from donors and churches and a pay as you go model, it has grown to be a Kenyan Health Center offering a variety of services from dentistry and optometry, to maternal health care and family counseling. The health center has a dental technician, an optrician, two nurses, a physician assistant, and two nurse-midwives. They have limited lab abilities, no physician, no radiology, and no ambulance or quick way to get an emergent patient to higher level of care (nearest hospital is in Eldoret, more than an hour away if lucky).

As Navy family physicians, one aspect of medical care that we get a lot of practice in is delivering babies and providing neonatal resuscitative care. It was these learned skills and experience that I hoped to bring to the Chebaiywa Health Center to help and teach the current staff. I also wanted to learn about the typical medical diagnoses and issues they see here, many of which are very different from anything we see in the States.

My time in Kenya is well under way now and I am learning and experiencing new things every day, but there is much more to do and I hope to share it with you as I go, so look out for the next installment of my Kenyan journey soon!

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Holly Durst
Great work over there Andy! Keep it up!

Ric Cruse
Well done Andy!

May Tjoa
This makes me so very proud of Dr. Andy Baldwin and the U.S. Navy- for protecting our citizens at home, and advancing lives in developing countries. Thank you very much!! @MayNBC

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  I think so

Lisa Remillard
Great work Andy! It must be heartbreaking to see this first hand but the work you and

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the other doctors are doing is changing lives one patient at a time.

Angie
Andy.. great work you are doing over there. You continue to inspire!

Valishia
Thank you for sharing your experience in Kenya, just when I needed it most! Our first Med4Nicaragua 2012 Mission meeting will be next week at Scripps Encinitas. To be honest the thought of organizing another mission, is not only stressful, but at times overwhelming and requires a lot of work. After reading your posts and seeing your pictures I am reminded why I do medical missions, because these people need our help! You have motivated me and inspired me! Thank you for dedicating your time to help the people of Kenya and for reminding me why I am called to do missions. God Bless!

Bill Crounse, MD
Excellent work, Andy. I'm so pleased that you selected family medicine as your career choice.

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Victor Morrison
Lt Cmdr Baldwin -

My name is Victor Morrison. I am leading two groups of 20 to Southern Kenya in the spring of 2012. Both teams will be building churches and providing medical care. Team 1 will be traveling to Entoroto, about 1.5 hours south of Narok. Our team in Entoroto will be providing basic sick call type of medical care under the local acacia tree.

I am interested to know if you would have any suggestions of what types of medical supplies we should bring/purchase in Kenya.

I thank you in advance for your help.

Victor Morrison
Kenya 2012 Work & Witness team leader

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Written on OCTOBER 24, 2011 AT 8:30 AM *by* PROSS

Lt. Cmdr. Andy Baldwin Highlights His Medical Mission in Kenya (Part 2 of 2)

Filed under UNCATEGORIZED [4 COMMENTS]

By Lt. Cmdr. Andy Baldwin, Family Medicine resident, Naval Hospital Camp Pendleton, Calif. Lt. Cmdr. Baldwin is participating in a month long rotation in Western Kenya as part of his Family Medicine Residency at Naval Hospital Camp Pendleton, Calif.

Lt. Cmdr. Andy Baldwin is participating in a month long rotation in Western Kenya as part of his Family Medicine Residency at Naval Hospital Camp Pendleton, Calif.

Hello again! I've been in Kenya for a couple of weeks now and wanted to provide you all with a progress report and give you an idea of the crucial work we're doing over here. It's been an eye opening experience for me so far and such a departure from everything I'm accustomed to in a military family residency back in the U.S. I think the story I am going to share with illustrate some of what I mean.

Just days after my arrival at the Chepaiywa Health Center in the Rift Valley Province, I was teaching the staff the Neonatal Resuscitation Program when a woman presented in labor with her fifth child. After delivering well over 100 babies at Camp Pendleton, Calif. over the past year in a controlled and highly monitored environment, the ensuing delivery showed me first hand a true "natural" delivery. Much of what I had learned, if not all, about the process of monitoring and delivery of a child went out the window.

The woman had no records, especially not an electronic medical record on the Armed Forces Health Longitudinal Technology Application (AHLTA). I had to rely on the size of her abdomen and doing what we call maneuvers to estimate the size of the baby and how many weeks along she was. By my estimation she had to be at least 37 weeks gestation which is term and a good thing. As any of you who've been party to a conventional birth in the U.S., whether as a mother, delivery doctor or nurse, or even as an excited father-to-be know, with a modern equipment setting this patient would be checked in and put on continuous monitoring of her fetal heart rate and the strength and frequency of her contractions. She also would have had screening for diabetes of pregnancy, anemia, high blood pressure, and bacterial infections. But this woman had none of these.

Her "sister," in fact, insisted on doing the check of seeing how far along she was in terms of dilation, of which I promptly followed, and felt her four centimeters dilated and able to feel what I thought was the head of the baby. This was good but not incredibly reassuring since you never want to deliver a baby vaginally feet first (breech). Usually you rely on an

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ultrasound machine to prove that the baby's head is down. Not in this case. I also relied on a "fetascope" to check the baby's heart rate. This is basically a plastic horn shaped device that you put one end to your ear and the other to the woman's abdomen and listen for the heart beat. I heard the heart beat, but there was no electronic monitoring here.

This woman was in active labor and having contractions every two minutes, and had no anesthesia. There is no such thing as an "epidural" in this part of the world. Yet, she was stoic as could be. After being checked for the status of her baby I watched as the woman put her sandals back on and walked down the dirt path. "Where is she going," I shouted in bewilderment. "She's going home, but hopefully she'll be back," said one of the nurses. This defines the overwhelming feeling here of "Hakuna Matata," which if you've seen Disney's *The Lion King* you know means "no worries, it's all good." If the mom delivers at home, it's okay. If the baby doesn't make it, it is sad, but it's okay. It's not our responsibility to deliver this baby. We are here to help if she wants it. I looked up and took a deep breath and tried to eliminate the first-world medicine mindset from my head.

The woman did return several hours later with even stronger and frequent contractions, yet she remained her same stoic self, not uttering a word, and just occasionally wincing in pain. I checked her status, and she was almost fully dilated and ready to start pushing. She had a colorful dress on and assumed a squatting position in the delivery room of the clinic which basically just had a table, scissors and some sterile gloves. There were no footrests, no sterile delivery area/sheets, and other than the occasional listen by the fetoscope, we had no idea what the baby's heart rate was.

I asked the woman in Swahili whether she wanted a boy or a girl, and she replied girl. Only time would tell. Unlike in the U.S. where a second trimester ultrasound will let us know the sex of the child, this was surprise at delivery. If it were a girl, she would name her Joy. I had a presumption she would deliver quickly, and almost seeing the baby's head crowning as she was doing a squat I urged her to get on her back on the table and for the others to get gloves on and be ready to help the baby if needed. The suction device for the baby looked like a large turkey baster. I delivered the head without issue, but with the woman's small pelvis, I realized that we had a shoulder dystocia, meaning the baby's shoulders were stuck. I used the skills I had been taught at Naval Hospital Camp Pendleton, Calif. and took the steps necessary to deliver the shoulders. For a second I thought I would have to break the baby's clavicle to get the shoulders through.

The clock was ticking and none of us had any idea of whether the baby's heart rate had been low and there had been a deprivation of oxygen to the baby. Joy it was! As the sex revealed a girl, I cut the cord, but noticed that baby Joy looked awfully pale and was not crying. The nurses looked at me not knowing what to do. The time for neonatal resuscitation was now! Using the suction, and tactile stimulation I was able to clear the airway and reaching for a ventilator bag-valve mask was able to give some rescue breaths. After what seemed like an eternity, Joy let out a cry.

I breathed a sigh of relief and continued to ensure she was breathing. Her mother by this point had delivered the afterbirth and was in a pool of blood, and I rushed over there and was able to do some massage of her uterus to get it to firm up and stop the bleeding. She smiled and got off of the bed in complete control, said "Asante" (thank you) to me, and picked up her baby and immediately started nursing her on the breast. She then proceeded to put her sandals on and walk home with her new baby. I looked at my watch. This had all occurred within 30 minutes, and now the mother and baby were on their way home.

A thousand things rushed through my head, "what if the baby had aspirated and would get a lung infection," "what if she had trouble breathing," "what if she couldn't feed well?" This is the reality of natural child birth, which has been taking place since the beginning of time — only some babies and mothers make it through.

If you get pregnant 10 times, and five of the children make it, then this is the way it is. In many areas of Kenya, this is how it still happens. In the area of Kipkaren, with the Chebaiywa Health Center, we are working to change this, and in this case I am glad that things did not take place fully naturally, for if that were the case, baby Joy may not have made it. With basic education around neonatal resuscitation many more Joys will make it as well and I hope to help facilitate for the wonderful people and a truly beautiful culture.

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May Tjoa
This is incredibly thought provoking and educational. I'm learning so much from Dr. Andy Baldwin's medical mission- it is changing how I think.
@MayNBC

Sharon Dietrich
Just a few thoughts for Dr. Baldwin: I am a Family Doctor, just retired. You mention several times that in U.S. hospitals, we do continuous fetal monitoring during labor, routine ultrasounds, etc. etc. There is no evidence that continuous fetal monitoring is at all predictive of fetal outcome, and even ACOG states that intermittent monitoring(with fetoscope–a tool I used a lot when I trained and early on in practice) is quite acceptable. Determining position by exam is a good tool to have, as well. Our neonatal outcomes, despite all our technology, are not as good as many nations, even some that are not "first world". Many of us our in the real world actually try to let women labor as naturally as possible(walking, positioning, etc), and let them choose the position for delivery. I rarely use the dorsal lithotomy position(unless the woman requests–a rare thing), I do bed deliveries, often on the woman's side. Dystocia is usually not an issue in that position, and almost never in knee-chest position.

Your maneuvers to resolve dystocia are always good tools to have, but remember prevention as well. Congrats on the resuscitation–in almost all cases, a little oxygen is all it takes!!

Your experience must be eye opening and wonderful in Kenya!! Some of what you learn can be translated into US medical/obstetrical care, I am sure.

Sharon Dietrich MD

Chris Porter
Very humbling to practice in the developing world. Thanks for sharing your experience. I saw some of the unlucky mothers in Sudan and Tanzania. People
Forget that natural and safe are not the same.

Bob Landes
Andy,
Good story! I am working with a group seeing about electronic medical records in the underdeveloped world – read, most of the world! If you had that capability, what would you REALLY want and need – remember, you are not billing, and coding is different.

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Are there repeat visitors to the clinic? Could you create an identifying system for the patients – has to be yours since it is not important to the people. I have a telephone appointment Monday, October 31, and would appreciate some input. Thanks, Bob Landes